

Topic 5

NEW INITIATIVES: PRIVATE SECTOR AND SOCIAL FINANCING

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Two additional possibilities for increasing access and expanding resources for health care are under scrutiny, as African ministries of health (MOHs) refine their cost recovery and resource allocation strategies:

- > expanding the role of private providers in furthering public health goals (e.g., non-governmental health care providers, for-profit providers)
- > finding alternative financing mechanisms for health care (e.g., private insurance, community-based social financing, employer-based insurance plans).

Both initiatives have a base in every sub-Saharan African country, but experience with expanding private services and health insurance is limited, and not every avenue has been exploited. *Topic 5* presents some of the most commonly asked questions and arguments for and against these initiatives.

QUESTION 19: Who are the private providers and what can they contribute to the public health agenda?

In Brief: Private health care in sub-Saharan Africa includes services provided by non-governmental organizations (NGOs), enterprises, for-profit medical personnel, and traditional practitioners. Depending on their size, scope, and nature of care provided in each country, these providers can help ministries meet goals for improving the availability, quality, and efficiency of health services and free the government of responsibility for people who can afford to pay. Ministries also need to take steps to avoid possible harmful effects.

What private sources already provide health care in Africa?

Private providers of health care in Africa include:

- > non-governmental, non-profit providers of services who usually charge modest fees with exemptions for the poorest people. This group includes religious, community, and private voluntary providers.
- > for-profit providers, who charge fees to cover costs plus profit. This group includes offices operated by individual physicians or nurses, privately operated clinics and hospitals, and traditional healers.
- > employer-based health service providers, who provide selected services for employees and sometimes their families. This group includes company clinics and health personnel under company contracts.

What part do private providers play in the delivery of health care in Africa?

Non-governmental providers, especially church missions operating on a non-profit basis, are likely to be the largest private providers of western medical health care in most African countries. Usually, they serve rural and urban poor populations, providing curative and preventive care in both primary care and hospital settings.

- > In Tanzania in 1991, for example, voluntary agencies were responsible for almost as much hospital capacity (11,341 beds) as the government (12,548 beds). [10]
- > In Uganda, non-governmental organizations (NGOs) operate 36 of the 50 secondary and tertiary hospitals (72 percent, with 63 percent of the bed capacity). [13]
- > In Zambia, mission bed capacity (6,358) is equal to 38 percent of MOH bed capacity and 25 percent of the country's total bed capacity.[2]

The number of *for-profit health service providers* and the complexity of services offered differs widely, within as well as between countries. *Traditional healers* are usually the largest group of individuals providing health care for a profit in sub-Saharan Africa.

Some countries have just recently authorized for-profit provision of western medicine (e.g., Tanzania, Mozambique), while others have had a for-profit western sector for many years (e.g., Kenya). In some countries, retired MOH personnel set up private practices. In others, ministries a

BOX 5-1 QUALITY VS EFFICIENCY?

Many people insist that the private sector is more efficient than the public sector in providing health services. Others argue that the private sector sacrifices quality to efficiency. Actually, there is little evidence to confirm or deny either allegation.

- > In Senegal, one study showed that—at about the same cost—non-governmental private providers (church mission facilities) were more efficient than public providers (as measured by number of visits per health worker). They also provided higher quality services (as measured by compliance with treatment protocols, other clinical factors, and patient and provider satisfaction). But the same study also found that for-profit providers and company-based clinics offered less efficient and lower quality care than the non-governmental providers.¹
- > In Kenya, another study showed similarly mixed results. Using a quality ranking method, researchers found that of the top five overall quality scores, two were government and three mission facilities. The mean cost per outpatient visit was lower in government facilities than in mission facilities. The study concluded that generalizations about relative efficiency of government and mission health services could not be made and that management practices are more important than ownership in determining efficient provision of health services.²
- > In Tanzania, less than half the church-based and other voluntary agency health facilities in Dar es Salaam followed acceptable clinical practice, a substantial percentage had potentially serious clinical errors, and many experienced stockouts of essential drugs.³

Sources:¹Bitran et al. 1994; ²Data for Decision Making Project,

as a substitute for directly provided employer health services.

- > In Tanzania, where health insurance is in its infancy, half the 200 employers recently surveyed directly provide some kind of health services for employees through contracts with private or mission facilities or through their own clinics and hospitals. The rest of the employers had some kind of insurance or reimbursable arrangement. [10]
- > In Nigeria, five large parastatals offer their employees and their families comprehensive health care at company facilities or under contracts with private hospitals and doctors. [16]

How can private providers contribute to public health goals?

An increase in the number and kind of private sector providers could help ministries of health to:

- > improve overall availability and accessibility of health services and medicines, while relieving the government of having to provide that additional care directly
- > increase availability of health services for the underserved, hardest to reach, and lowest income populations
- > increase overall efficiency of health service delivery by permitting government to take advantage of efficiency gains by private providers
- > reduce government funding for health services that people can and will buy with out-of-pocket or insurance-based payments.

Mission health providers, for example, could contribute to public health by maintaining and expanding their capacity for delivering high-quality services, especially priority preventive services, to poor and underserved populations at prices they can afford.

For-profit providers can contribute most by delivering care to people who could pay but who use free, or highly subsidized, public care. This would help to free public resources for people less able to pay.

- > In Kenya, private health facilities provide about 20 percent of all childhood immunizations, about 16 percent of all maternal deliveries outside the home, and 24 percent of the diarrhea treatment in rural areas and 14 percent in urban areas. Mission health facilities treat between 20 percent and 30 percent of tuberculosis cases and diagnose and refer between 10 percent and 20 percent more. The high cost of TB medications in the private market has led to a reduction in the number of cases treated in the private for-profit sector. Missions, private hospitals and clinics, and private shops treat an estimated 27 percent of childhood fevers and coughs. [4]
- > In Zambia, private health providers give 17 percent of all measles vaccinations in rural areas and 17 percent in urban areas. They also treat 22 percent of childhood diarrhea cases in rural areas and 24

percent of urban cases as well as 24 percent of the rural cases of childhood fevers and coughs and 38 percent of the urban cases. [2]

Traditional health care providers can contribute through their wide accessibility and users' confidence in them. Many African health ministries have furnished traditional health care providers with training and materials to upgrade the quality of their services. For example, retrained traditional birth attendants have long helped to widen rural and village access to safer childbirth services and to extend health education messages.

Employer-based clinics offer many people a range of quality health services and can make an important contribution to health services wherever they are prevalent.

How should ministries prepare for a large or expanding private health care sector?

Expanding private sectors can create public-private competition for patients and for health personnel. This competition can have beneficial or harmful effects depending on how it is handled. Government cost recovery initiatives and the financial sustainability of public health services could be jeopardized if for-profit providers draw most of the paying patients away from the public sector. Public health facilities with cost recovery underway need to be able to compete equally in price and quality with private providers.

In addition, increasing opportunities in the private sector and the prospect of larger incomes often attract health personnel away from the public sector. Employment conditions and incentives in the public sector need to improve in these cases. Many MOHs permit "moonlighting" to accommodate this situation, but few of them have yet found an ideal way to contain the abuses that can occur.

Many people argue that the private sector is always more efficient than the public sector and provides higher quality services. Given the wide diversity of private providers, however, such generalizations should be viewed with skepticism. Ministries generally need to increase their capacities for regulating quality, enforcing licensing and accreditation procedures, and monitoring facility health and safety standards as the private sector expands. (*See Box 5-1*)

QUESTION 20: How can government encourage private delivery of health care services?

In Brief: Laws, regulations, and funding arrangements have been government's main ways of encouraging or discouraging the growth of private health care providers. Permissive and supportive laws and regulations alone are often all that is needed for a private sector to begin to flourish. Ministries should undertake assessments to determine the cost-effectiveness of various public financial incentives for the private sector, compared with benefits that might come from spending the same sums to improve public providers.

What are the main options for support to the private sector?

Government can encourage private providers by offering them direct subsidies or contracts for specified services and/or services to target groups. They can also enact laws, regulations, and tax codes that create incentives or remove disincentives for the kinds of private services government wants.

Subsidies, paid in the form of bed grants, staff grants, equipment and basic operating grants, have been one of government's most common types of support to private providers. These subsidies have been offered almost exclusively to non-governmental health providers covering underserved populations.

Similar support could be given to company clinics or for-profit providers in underserved areas. Incentives can be created to expand coverage to the community with direct subsidization of important cost-effective health interventions. These providers can also be encouraged to add to their own service delivery base any services necessary to meet MOH priorities. A subsidy for the marginal cost of adding services may cost less than establishing or maintaining MOH capacity to serve that population.

To be reasonably certain subsidizing private providers is more cost-effective than improving or expanding existing government health services, however, ministries must run the cost and effectiveness numbers before acting.

Where do laws, regulations, and tax codes come into the picture?

Laws, regulations, and tax codes are very important for for-profit private sector health providers. Together with tight credit, the absence of such laws can do more to keep private providers from expanding than limited demand from a poor population. Both credit and law-making are within government control.

- > Tanzania exemplifies the effect of legalizing private medical practice. After the broad legalization of private for-profit health practice, the number of all private health providers in the capital, Dar es Salaam, almost doubled, from 136 in 1991 to 253 by 1993. [10]

What is government already doing to encourage private providers?

- > Zimbabwe and Nigeria grant tax relief to private voluntary agencies. Mozambique has recently adopted legislation to allow private voluntary organizations to establish health care facilities and to allow private companies to establish and run clinics for employees. [16]
- > The Tanzanian government has traditionally provided most of the staff and financial support (95 percent of total costs) to non-governmental, voluntary agency health providers to operate 17 district hospitals owned by voluntary agencies. These public-private facilities, known as *designated district hospitals*, serve as key health facilities in the public health system, providing free medical services for everyone. Government pays the remaining voluntary hospitals subsidies equivalent to between 4 percent and 9 percent of their revenues. [10]
- > In Zimbabwe, the health ministry spends about 4 percent of its budget to subsidize church mission health care for indigents. This subsidy is about 85 percent of the mission's revenues for these services. Zimbabwe is also trying to contract out to private organizations functions related to equipment, maintenance, laundry services, and insurance reimbursement billings. [13]

QUESTION 21: What are the main ways of sharing the risks or easing the burden of paying for health care?

In Brief: Patients or clients can pay the full cost of health care when they use a service, or they can pay through a variety of other methods, often called *social financing*. Social financing helps people spread the risk and cost of medical care by pooling resources, usually through premiums or tax payments to central or local governments. In sub-Saharan Africa, individual financing predominates in traditional health care. Social financing predominates in western medical care, mainly in the form of government-provided, tax-financed health services for the whole population. Private insurance is limited but on the rise in several countries.

What forms do social financing risk-sharing arrangements take?

Three broad types of social financing arrangements for health care are prevalent in Africa:

- > government health services for the whole population
- > traditional, formal insurance arrangements for public and/or private sector employees
- > community-based insurance and prepayment plans.

Specifically, social financing for health services in sub-Saharan Africa is provided in different ways, including:

- > direct government health care financed by general tax revenues (e.g. all government-provided health services)
- > government-mandated health insurance for all employed workers, financed by taxes on employee wages and on the employer payrolls, and government-financed health benefits for all civil servants (e.g., compulsory social security for the entire formal labor market in Senegal and Mali, government-mandated employer coverage of health care in Zaire; Kenya National Hospital Insurance Fund for employees in the formal sector; government programs for civil servants in most African countries)
- > voluntarily provided employer-sponsored health insurance plans that provide services either directly through on-site health facilities or rely on contracts with outside providers (e.g., Zambia, Nigeria, Liberia, Senegal, Zaire, Kenya)
- > community-sponsored prepayment and rural insurance plans, under which households or adults pay a fixed sum once or twice a year, and sometimes a copayment at the time of use, for services delivered at a local health facility (e.g., in Zaire, the Bwamanda rural hospital insurance program; in Guinea-Bissau, community-level prepayment funds for primary health

care and drugs at village health posts; drug revolving funds in many localities; in Kenya, Harambee Movement funds for catastrophic illnesses)

- > group and individual private health insurance plans (e.g., in Côte d'Ivoire, Ghana, Kenya, Senegal, Zimbabwe). [8,9,11,13,14,15,16]

How important is government-sponsored social financing in sub-Saharan Africa?

Governmental, tax-supported health care is by far the predominant form of social financing in sub-Saharan Africa. Free government health care for every person is the equivalent of universal health insurance, with no copayments or deductibles. User fees for cost-sharing are the equivalent of copayments for services. Theoretically, universal government systems draw on the largest risk pool by spreading the costs of health care across the whole population. In progressive tax systems, this financing structure involves strong elements of equity.

How common is traditional health insurance coverage in Africa?

Insurance and prepayment plans are receiving more and more attention as governments introduce financing reforms in the public sector. Health insurance with third-party reimbursement (via social security, other public insurance, or private insurance) is most common for wage-earners in the formal economy. Coverage ranges from none in many countries to between 15 percent and 25 percent of the population in Burundi, Namibia, Senegal, and Kenya. Health insurance is available primarily to urban and middle-income or upper income households. [13,15] Insurance coverage for employees is growing in many countries and has doubled in some (e.g., Senegal and Kenya) since the mid-1980s. [16]

The number of sub-Saharan Africa countries with formal health insurance systems has doubled from 7 in 1990 to 14 in 1993. Seven countries have social security systems that provide medical benefits, 15 countries require employers to pay for certain medical services, 17 have no formal health insurance system, and 8 have no information available. [13,15]

What else is going on in the realm of health insurance in Africa?

A variety of community-based, rural insurance and prepayment plans have been developed. (*See Question 22*) Employers and other groups in several African countries have also developed some informal insurance, prepayment, and benefit plans to share the costs of health services.

Employer innovations in health insurance and health benefit plans seem to offer more potential for social financing than once imagined for use in health care financing reform.

- > In Zaire, employer-organized insurance plans provide about 30 percent of revenue in Kasongo Health District, which has 30,000 urban and 165,000 rural residents. About 60 percent of the district hospital's revenue comes from insurance, compared with about 13 percent at health centers. [13]

- > In Zimbabwe, private insurers covered less than 5 percent of the population in the late 1980s. Yet insurance payments made up almost 17 percent of all expenditures on health care, equivalent to a third of central government expenditures. [13]
- > In Senegal, private insurance grew rapidly in 1987–90 as 15,000 people enrolled in plans offered by eight companies. Total insurance financing doubled over an eight-year period, from F CFA 4.4 billion in 1981 to F CFA 8.8 billion by 1989. Current transfers through health insurance amount to about 20 percent of total health expenditures. [16]
- > In Tanzania, 193 out of 200 employers recently surveyed had some kind of health insurance, prepayment, or benefit plan for employees. About half of them had contracts with private or mission health facilities or ran their own clinics or hospitals; 20 percent reimbursed employees' medical expenses; the remaining 30 percent used other variations on these two approaches. About 90 percent of the plans were open to all employees, and most covered at least some dependents. Under all public and private employee health benefit plans, 13 percent of the population (employees and dependents) is covered. [10]
- > In Kenya, there are three broad types of health insurance arrangements: the government-mandated hospital insurance and workmen's compensation for employed workers, community-based Harambee Movement funds, and private insurance funds offering individual, group, and employer-based health benefits. About a quarter of the 38 registered insurance companies sell medical insurance separately; the other companies package some health insurance with other insurance policies (e.g., for fire, theft, motor vehicles). Most insurance companies are located in the capital, Nairobi, but they use about 3,000 brokers and agents to market their policies countrywide. These health insurance policies most often cover hospitalization, therapeutic drugs, and surgery. The number of group health insurance policies increased by 265 percent in 1980–91.

Private employers in Kenya are the main purchasers of traditional health insurance. Small or unregistered businesses hold about 20 percent of the health insurance policies. Employers provide either formal group insurance or reimburse employees for their health expenses (22 percent) or provide health services directly in a company clinic or by reimbursing another provider directly (30 percent). [11]

QUESTION 22: Are insurance and other forms of social financing appropriate for low-income rural populations in Africa?

In Brief:

Cost recovery reforms in the public health system prompt consideration of other financing arrangements to help sustain user fee systems and make them affordable and equitable for patients— especially low-income and rural households. These other arrangements— such as traditional individual or group insurance, various forms of prepayment plans, or community-based funds earmarked for health care—can be run separately from, or in conjunction with, the government system. Many countries already use some of these alternatives, especially variations of community-based plans, but their use could be further encouraged. Insurance also brings disadvantages that must be guarded against. Some lessons have been learned about appropriate measures to include in the design and implementation of these plans so that they are effective for low-income african populations.

As governments in sub-Saharan Africa look more and more to user fees to cover costs, what advantages do insurance and prepayment plans offer?

Most countries in sub-Saharan Africa that have undertaken major health financing reforms have concentrated on changes within the framework of the long-established, predominant form of social financing — tax-financed, free services provided directly by government. The main change has been the introduction of user fees, a form of copayment covering part of the cost of care in government health facilities. Introduction of these changes has raised the importance of other social financing mechanisms— especially traditional health insurance or simpler prepayment schemes— to complement and support user fees.

Insurance and prepayment plans are an additional means to:

- > improve access and equity by spreading the risks and costs of health services across a large group of users
- > reinforce cost recovery efforts by allowing increases in user fees. This mobilizes additional revenues to help fund public health services and frees resources for important public health services not covered by insurance.
- > relieve the government's budget of responsibility for subsidizing health care, especially expensive hospital care, for people who can afford to pay
- > encourage diversification among public and private healthcare providers
- > improve the likelihood that private and public health providers will receive payment for their services.

How do rural insurance and community-based social financing work?

Under *community-based social financing plans*, each year people pay a fixed sum of money per household or per adult. These arrangements are based on the premise that people pay in advance to (1) protect themselves from possibly high and unaffordable health care costs and (2) spread the cost of health services over the sick and the not sick. If premium or tax payments are graduated according to income, comfortable households would also help to pay for lower income community members.

A community health committee usually manages these funds to support health services at the local dispensary, health post, or health center. Local committees set fees for services and medicines and make rules for exemption from payment (e.g., for the indigent, chronically ill, or disabled). Benefits are usually limited to services available within the community. African communities have used this form of community financing for both primary and preventive health care as well as for hospital care.

Several African countries are using *rural social financing and insurance plans*.

- > In Niger, the Ministry of Health recently experimented with a social financing plan in a rural district as part of a test of alternative cost recovery methods for improving quality and use of primary and preventive health care services at non-hospital health facilities. The plan involved payment of a local tax of FCFA 200 per adult (\$0.78 before the 1994 devaluation) and a fixed copayment per episode of illness, with preventive health services (e.g., immunizations, prenatal care) free of charge. The copayment, higher for adults (F CFA 50, \$0.20 before devaluation) than for children under age 5 (F CFA 25, \$0.10), entitled patients to whatever medicines were needed for treatment. [5] Based on success of this plan, the government has authorized extension of the system nationwide. (See Box 5-2.)
- > In Zaire, the Bwamanda health zone instituted an insurance program as a means of generating revenue for its reference hospital and organizing service delivery. People pay a fixed premium per household member once a year. The plan covers only hospital services and chronic care treatment in health centers. It is managed by the health zone and enrollment is voluntary, but the whole family must enroll, if one member does. When using hospital services, plan participants pay 20 percent of the uninsured patient fee. Enrollment rose from an initial 30 percent of the community in 1986 to 60 percent in 1989. Since the second year of operation, income to the plan from premiums and interest has exceeded costs of covered health services

BOX 5-2 LOCAL TAX + COPAYMENT

In a poor rural district in Niger, a social financing method using a local tax plus copayment for each episode of illness was found effective and acceptable in a pilot test. This method worked better than a direct fee-for service by raising more revenue, covering a higher percentage of medicine costs, receiving higher community satisfaction ratings, and resulting in higher utilization rates. Both test districts preferred social financing to a straight fee for service because they thought it was easier and less expensive at the time of use. In addition, lower-income as well as higher-income residents said they would be willing to pay higher taxes if that assured ready supplies of medicines.

Source: Diop et al 1994. [5]

for members. Administrative costs are only 5.7 percent of premiums. Hospital charges are about 90 percent of the plan's costs, and health center charges for chronic care are about 5 percent. Drug stockouts are rare. [14]

- > In Guinea-Bissau, village-based systems of prepayment started in 1980 after government introduced user fees in the national health system. The prepayment funds (*abotas*) help assure a supply of a limited number of drugs at village health posts because people do not have cash available for much of the year. Details of each of the village systems vary, but most adults contribute twice a year and are given receipts entitling them to free consultations and drugs and any necessary free referral to the next higher level of care. Each village committee sets its own prepayment rate (e.g., flat rate per adult or higher for men), decides whether to accept in-kind payments, and decides who pays (e.g., all adults, men only, or households), and who receives free services without any prepayment (e.g., very poor, disabled, visitors who have emergencies).

In the 450 villages that have adopted these plans, 90 percent of their residents participate in them. But success has varied in recovering costs, maintaining drug stocks, and assuring improved utilization and quality of village health workers. To purchase more drugs, village sites surveyed have raised their initial prepayment rates at least once (average amounts collected per adult male in 1988 was the equivalent of \$0.20). Of the villagers surveyed, those who could were willing to pay more. Community control has protected funds from misuse. [6,18]

What are the drawbacks to insurance?

Many employer-based plans are less efficient for employers and less effective for employees than they might be. [3,16] Health insurance arrangements, when not carefully designed, can also lead to excessive costs and inequities between the insured and the non-insured. (See box 5-3.) The potentially negative effects bear special watching in the case of insurance covering hospital care. (See Question 18)

What are some earmarks of successful rural insurance and prepayment plans?

The still-limited experience with rural insurance and prepayment arrangements in sub-Saharan Africa suggests that successful programs:

- > ensure good access to quality care

BOX 5-3 PROS AND CONS OF INSURANCE

If health care services are to be affordable as countries introduce fees, more extensive use of health insurance or prepayment will probably become necessary in public health facilities. If user fees rise high enough to cover total recurrent costs, these or other forms of risk sharing will be needed, especially for inpatient care at major hospitals.

But to be of greatest benefit to reform efforts, insurance plans must be designed to avoid common problems: overuse of services by insured people, inequity between the insured and the uninsured, high administrative costs, and cost escalation stemming from inappropriate provider incentives.

Source: Shaw and Griffin 1995; Barnum and Kutzin 1993; LaForgia and Griffin 1993. [13,1,8]

- > limit benefits to keep premiums and prepayments affordable
- > set rates carefully to reflect expected utilization patterns and the population's ability to pay
- > encourage cost-effective utilization by including some form of copayment for services at the time of use
- > provide for flexible and convenient premium payments
- > target subsidies carefully to provide the maximum incentive to enroll in the plan
- > establish simple administrative, accounting, and control systems
- > market the plan aggressively so that consumers are well-informed about benefits, improved quality and potential savings from enrolling. [12,13,16]

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